

107TH CONGRESS
1ST SESSION

H. R. 2497

To amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to establish certain requirements for managed care plans.

IN THE HOUSE OF REPRESENTATIVES

JULY 12, 2001

Ms. VELÁZQUEZ introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to establish certain requirements for managed care plans.

1 *Be it enacted by the Senate and House of Representa-
2 tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Managed Care Bill of Rights for Consumers Act of
6 2001”.

7 (b) TABLE OF CONTENTS.—The table of contents of
8 this Act is as follows:

Sec. 1. Short title; table of contents.

Sec. 2. Patient protection standards under the Public Health Service Act.

“PART C—PATIENT PROTECTION STANDARDS

“Sec. 2770. Guarantee of medically necessary and appropriate treatment.

“Sec. 2771. Guaranteed adequate access to health care.

“Sec. 2772. Right to adequate physician network.

“Sec. 2773. Meaningful choice of providers.

“Sec. 2774. Guaranteed continuity of care.

“Sec. 2775. Right to specialty care.

“Sec. 2776. Required obstetric and gynecological care.

“Sec. 2777. Assuring equitable coverage of emergency services.

“Sec. 2778. Requirement for service to areas that include a medically underserved population.

“Sec. 2779. Right to language assistance.

“Sec. 2780. Prohibition on financial incentives to limit care.

“Sec. 2781. Prohibition on gag clauses.

“Sec. 2782. Right to appeal denial of care.

“Sec. 2783. External review.

“Sec. 2784. Nondiscrimination right.

“Sec. 2785. Protection of patient confidentiality.

“Sec. 2786. Establishment of Managed Care Consumer Advisory Commission.

“Sec. 2787. Requirements for prescription drug coverage; definitions.

“Sec. 2788. Notice; definitions; application of enforcement provisions.

Sec. 3. Patient protection standards under the Employee Retirement Income Security Act of 1974.

Sec. 4. Nonpreemption of State law respecting liability of group health plans.

Sec. 5. Effective date.

**1 SEC. 2. PATIENT PROTECTION STANDARDS UNDER THE
2 PUBLIC HEALTH SERVICE ACT.**

3 (a) IN GENERAL.—Title XXVII of the Public Health

4 Service Act is amended—

5 (1) by redesignating part C as part D; and

6 (2) by inserting after part B the following new

7 part:

1 **“PART C—PATIENT PROTECTION STANDARDS**2 **“SEC. 2770. GUARANTEE OF MEDICALLY NECESSARY AND**
3 **APPROPRIATE TREATMENT.**4 “(a) IN GENERAL.—A managed care plan may not
5 impose limits on the delivery of services if such services
6 are—7 “(1) medically necessary and appropriate as de-
8 termined by the treating health professional, in con-
9 sultation with the enrollee; and

10 “(2) otherwise a covered benefit.

11 “(b) SECOND OPINION.—A managed care plan shall
12 provide to an enrollee, upon request, a referral to a health
13 care practitioner for a second opinion as to what con-
14 stitutes medically necessary and appropriate treatment,
15 and provide coverage for such opinion without regard to
16 whether such health care practitioner has a contractual
17 or other arrangement with the plan for the provision of
18 such services to such enrollee.19 **“SEC. 2771. GUARANTEED ADEQUATE ACCESS TO HEALTH**
20 **CARE.**21 “(a) ADEQUATE ACCESS.—A managed care plan
22 shall provide adequate access to health care services.23 “(b) AVAILABLE ITEMS AND SERVICES.—The Sec-
24 retary shall ensure that items and services, including lab-
25 oratory and specialist services, covered under the plan

1 shall be available through providers that are reasonably
2 geographically accessible to all enrollees of such plan.

3 **“SEC. 2772. RIGHT TO ADEQUATE PHYSICIAN NETWORK.**

4 “(a) IN GENERAL.—A managed care plan shall main-
5 tain an adequate number, mix, and distribution of health
6 professionals and providers to ensure that covered items
7 and services are available and accessible to each enrollee.

8 “(b) ADEQUATE DISTRIBUTION.—The Secretary
9 shall determine the adequate number, mix, and distribu-
10 tion of health professionals and providers within the serv-
11 ice area of the managed care plan, including—

12 “(1) the existence of a primary care provider
13 network that is sufficient to meet adult, pediatric,
14 and primary obstetric and gynecological needs of all
15 enrollees;

16 “(2) the existence of a network of specialists of
17 sufficient number and diversity to meet the specialty
18 needs of all enrollees;

19 “(3) the access to quality health services from
20 institutional providers for all enrollees; and

21 “(4) the existence of at least one primary care
22 physician for every 1,500 enrollees.

23 **“SEC. 2773. MEANINGFUL CHOICE OF PROVIDERS.**

24 “(a) MINIMUM NUMBER OF CHOICES.—A managed
25 care plan shall provide to enrollees a choice of at least

1 3 providers within each category of providers based on the
2 health care needs of such enrollees, taking into account
3 the age, gender, health, native language, acute or chronic
4 diseases, and special needs of the enrollee. The enrollee
5 may change the selection of provider at any time.

6 “(b) ACCESS TO OUT-OF-NETWORK PROVIDER.—A
7 managed care plan shall cover services that are furnished
8 by a physician or provider obtained by the enrollee without
9 regard to whether such physician or provider has a con-
10 tractual or other arrangement with the plan for the provi-
11 sion of such services to such enrollees. The plan may im-
12 pose a reasonable deductible and reasonable copayment
13 subject to a reasonable annual limit on total annual out-
14 of-pocket expenses.

15 **“SEC. 2774. GUARANTEED CONTINUITY OF CARE.**

16 “If a contract between a managed care plan and a
17 health care provider is terminated (other than by the plan
18 for failure to meet applicable quality standards or for
19 fraud) and an enrollee is undergoing a course of treatment
20 from the provider at the time of such termination, the plan
21 shall—

22 “(1) notify the enrollee of such termination;
23 and

1 “(2) permit the enrollee to continue the course
2 of treatment with the provider during a transitional
3 period as determined by the Secretary.

4 **“SEC. 2775. RIGHT TO SPECIALTY CARE.**

5 “(a) REFERRAL TO SPECIALISTS.—

6 “(1) CHOICE OF SPECIALIST.—A managed care
7 plan shall permit each enrollee to receive specialty
8 care from any qualified participating health care
9 provider when such treatment is medically or clin-
10 ically necessary. The plan shall make or provide for
11 a referral to at least 3 specialists who are available
12 and accessible to provide treatment for such condi-
13 tion or disease.

14 “(2) COST OF TREATMENT BY NONPARTICI-
15 PATING PROVIDERS.—In a case in which a plan re-
16 fers an enrollee to a nonparticipating specialist, the
17 plan shall cover any services provided by such spe-
18 cialist at the rate it covers comparable services pro-
19 vided by participating providers.

20 “(b) CONTINUOUS REFERRALS.—A managed care
21 plan shall have a procedure by which an enrollee who has
22 a condition that requires ongoing care from a specialist
23 may receive a continuous referral to such specialist for
24 treatment of such condition, without additional authoriza-
25 tion from the primary care physician.

1 **“SEC. 2776. REQUIRED OBSTETRIC AND GYNECOLOGICAL**2 **CARE.**3 “(a) OBSTETRICIAN-GYNECOLOGIST AS PRIMARY
4 CARE PROVIDER.—In a case in which a managed care
5 plan provides for an enrollee to designate a participating
6 primary care provider, a female enrollee may designate a
7 physician who specializes in obstetrics and gynecology as
8 primary care provider.9 “(b) NO DESIGNATION OF OBSTETRICIAN-GYNE-
10 COLOGIST.—In a case in which an enrollee does not des-
11 ignate an obstetrician-gynecologist under subsection (a) as
12 a primary care provider, the plan shall not require prior
13 authorization by the enrollee’s primary care provider for
14 coverage of routine gynecological care and pregnancy-re-
15 lated services provided by a participating physician who
16 specializes in obstetrics and gynecology.17 **“SEC. 2777. ASSURING EQUITABLE COVERAGE OF EMER-
18 **GENCY SERVICE.****19 “(a) IN GENERAL.—A managed care plan shall cover
20 emergency services furnished to an enrollee of the plan—21 “(1) whether or not the provider furnishing the
22 emergency services has a contractual or other ar-
23 rangement with the plan for the provision of such
24 services to such enrollee; and

25 “(2) without regard to prior authorization.

1 “(b) EMERGENCY SERVICES.—Emergency services
2 shall include—

3 “(1) health care items and services furnished in
4 the emergency department of a hospital; and

5 “(2) ancillary services routinely available to
6 such department.

7 “(c) EMERGENCY MEDICAL CONDITION.—An emer-
8 gency medical condition is a medical condition manifesting
9 itself by acute symptoms of sufficient severity (including
10 severe pain) such that a prudent layperson, who possesses
11 an average knowledge of health and medicine, could rea-
12 sonably expect the absence of immediate medical attention
13 to result in—

14 “(1) placing the health of the individual (or,
15 with respect to a pregnant woman, the health of the
16 woman or her unborn child) in serious jeopardy;

17 “(2) serious impairment to bodily functions; or

18 “(3) serious dysfunction of any bodily organ or
19 part.

20 **“SEC. 2778. REQUIREMENT FOR SERVICE TO AREAS THAT**
21 **INCLUDE A MEDICALLY UNDERSERVED POP-**
22 **ULATION.**

23 “A managed care plan seeking to provide services in
24 an area that includes a medically underserved population
25 must submit a plan to the Secretary outlining a proposal

1 for service that ensures access to quality care that is ap-
2 propriate to the medically underserved population. The
3 plan shall include the health needs of the medically under-
4 served population with special consideration given to fac-
5 tors including age, gender, race, and potential chronic con-
6 ditions.

7 **“SEC. 2779. RIGHT TO LANGUAGE ASSISTANCE.**

8 “In a case in which 2 percent of the enrollees of a
9 managed care plan in a service area (as defined in section
10 2788(b)(9)) are members of a group that speaks English
11 as a second language or requires special communication
12 needs, the Secretary shall ensure that the managed care
13 plan provides communication assistance and bilingual in-
14 formation, on a continuous basis, to such enrollees. The
15 plan shall ensure that—

16 “(1) trained medical interpreters, whose pri-
17 mary responsibility is to interpret, are present in all
18 health care settings; and

19 “(2) an adequate number of health profes-
20 sionals receive training in cultural competency and
21 communication skills development as it relates to
22 medical interviews.

1 **“SEC. 2780. PROHIBITION ON FINANCIAL INCENTIVES TO**
2 **LIMIT CARE.**

3 “A managed care plan may not offer any financial
4 incentives, directly or indirectly, to health professionals as
5 an inducement to reduce or limit medically necessary serv-
6 ices provided to an enrollee.

7 **“SEC. 2781. PROHIBITION ON GAG CLAUSES.**

8 “(a) IN GENERAL.—The provisions of any contract
9 or agreement, or the operation of any contract or agree-
10 ment, between a managed care plan and a health profes-
11 sional shall not prohibit or restrict a health professional
12 from engaging in medical communication with his or her
13 patient.

14 “(b) NULLIFICATION.—Any contract provision or
15 agreement described in subsection (a) shall be null and
16 void.

17 “(c) MEDICAL COMMUNICATION DEFINED.—For
18 purposes of this section, the term ‘medical communication’
19 means a communication made by a health professional
20 with a patient of the health professional (or the guardian
21 or legal representative of the patient) with respect to—

22 “(1) the patient’s health status, medical care,
23 or legal treatment options;

24 “(2) any utilization review requirements that
25 may affect treatment options for the patient; or

1 “(3) any financial incentives that may affect
2 the treatment of the patient.

3 **“SEC. 2782. RIGHT TO APPEAL DENIAL OF CARE.**

4 “(a) ESTABLISHMENT OF SYSTEM.—Not later than
5 90 days after the date of the enactment of the Managed
6 Care Bill of Rights for Consumers Act of 2001, the Sec-
7 retary, through the Health Care Financing Administra-
8 tion, shall establish and implement guidelines for griev-
9 ance and appeals procedures regarding any aspect of a
10 managed care plan’s services, including complaints regard-
11 ing quality of care, choice and accessibility of providers,
12 network adequacy, and compliance with the requirements
13 of this part.

14 “(b) NO REPRISAL FOR EXERCISE OF RIGHTS.—A
15 managed care plan shall not take any action with respect
16 to an enrollee or a health care provider that is intended
17 to penalize the enrollee, a designee of the enrollee, or the
18 health care provider for discussing or exercising any rights
19 provided under this part (including the filing of a com-
20 plaint or appeal pursuant to this section).

21 **“SEC. 2783. EXTERNAL REVIEW.**

22 “An external review process shall be available to en-
23 rollees after all internal appeal options have been exer-
24 cised. The requirements for an external review process are
25 as follows:

1 “(1) The process is established under State law
2 and provides for review of decisions made pursuant
3 to section 2783 by an independent review organiza-
4 tion certified by the State.

5 “(2) If the process provides that decisions in
6 such process are not binding on managed care plans,
7 the process must provide for public methods of dis-
8 closing frequency of noncompliance with such deci-
9 sions and for sanctioning plans that consistently
10 refuse to take appropriate actions in response to
11 such decisions.

12 “(3) Results of all such reviews under the proc-
13 ess are disclosed to the public, along with at least
14 annual disclosure of information on managed care
15 plan compliance.

16 “(4) All decisions under the process shall be in
17 writing and shall be accompanied by an explanation
18 of the basis for the decision.

19 “(5) Direct costs of the process shall be borne
20 by the managed care plan, and not by the enrollee.

21 “(6) The managed care plan shall provide for
22 publication at least annually of information on the
23 number of appeals and decisions considered under
24 the process.

1 “SEC. 2784. NONDISCRIMINATION RIGHT.

2 “A managed care plan may not discriminate (directly
3 or through contractual arrangements) against an enrollee
4 or a provider on the basis of race, national origin, gender,
5 language, socioeconomic status, age, disability, health sta-
6 tus, or anticipated need for health services.

7 SEC. 2785. PROTECTION OF PATIENT CONFIDENTIALITY.

8 “A managed care plan shall establish policies and
9 procedures to ensure that all applicable laws that protect
10 the confidentiality of an individual’s medical information
11 are followed.

12 "SEC. 2786. ESTABLISHMENT OF MANAGED CARE CON-

13 **SUMER ADVISORY COMMISSION.**

14 "(a) ESTABLISHMENT.—The Secretary shall estab-
15 lish and appoint a 5 member Managed Care Consumer
16 Advisory Commission (in this section referred to as the
17 'Commission').

18 "(b) PURPOSE.—The purpose of the Commission is
19 to assist consumers in the following areas:

20 “(1) Accessing appropriate and high-quality
21 health care services.

22 “(2) Understanding and exercising their rights
23 and responsibilities as managed care plan enrollees.

24 “(3) Making an informed and appropriate
25 choice of a managed care plan.

1 “(c) MEMBERSHIP.—Members of the Commission
2 shall—

3 “(1) be selected from nonpartisan labor, reli-
4 gious, human service, or consumer organizations;
5 and

6 “(2) demonstrate a commitment to representing
7 consumers in an equitable manner.

8 “(d) DUTIES.—

9 “(1) ANALYZE AND COLLECT INFORMATION.—
10 The Commission shall collect and analyze informa-
11 tion for the purpose of identifying—

12 “(A) recurring barriers to access to health
13 care for persons enrolled in managed care
14 plans;

15 “(B) patterns of national, regional, or local
16 access problems with special focus on under-
17 served and vulnerable populations and persons
18 with chronic illness and disabilities;

19 “(C) quality of care problems; and

20 “(D) the extent to which managed care
21 plans comply with Federal laws, regulations,
22 and rules governing their responsibilities and
23 performance.

24 “(2) PROMOTE SOLUTIONS.—The Commission
25 shall investigate, identify, and promote solutions re-

1 garding managed care practices, policies, laws, or
2 regulations that adversely affect, or fail to promote,
3 informed access of individuals and populations to
4 high-quality health care.

5 “(3) REPORT.—Not later than January 1 of
6 each year, the Secretary, through the Commission,
7 shall submit a report to Congress which shall
8 include—

9 “(A) a description of the efforts of the
10 Commission; and

11 “(B) findings and recommendations based
12 on problems identified to improve consumer and
13 enrollee rights and protections so as to facilitate
14 access to high-quality health care and improve
15 health outcomes.

16 "SEC. 2787. REQUIREMENTS FOR PRESCRIPTION DRUG
17 COVERAGE.

18 "(a) REQUIREMENT FOR COVERAGE OF MEDICALLY
19 NECESSARY AND APPROPRIATE DRUGS.—In a case in
20 which a managed care plan provides coverage for prescrip-
21 tion drugs, such plan may not limit coverage if a treating
22 health professional determines that such coverage is medi-
23 cally necessary and appropriate.

24 "(b) REQUIREMENT FOR SUBSTITUTING DRUGS.—

1 “(1) IN GENERAL.—A determination as to
2 whether or not a drug prescribed to treat a medical
3 condition may be substituted with a different drug
4 may only be made by a treating physician. A man-
5 aged care plan may not provide a standard for sub-
6 stituting prescription drugs.

7 “(2) GENERIC DRUGS.—A generic drug may
8 not be substituted for a name brand drug unless it
9 has the same chemical composition as the name
10 brand drug.

11 “(c) LIMITATION ON ACCESS.—A managed care plan
12 that provides prescription drug coverage may not limit ac-
13 cess to drugs covered solely on the basis of costs associated
14 with providing coverage of such drugs.

15 **“SEC. 2788. NOTICE; DEFINITIONS; APPLICATION OF EN-**
16 **FORCEMENT PROVISIONS.**

17 “(a) NOTICE.—A managed care plan under this part
18 shall comply with the notice requirement under section
19 711(d) of the Employee Retirement Income Security Act
20 of 1974 with respect to the requirements of this part as
21 if such section applied to such plan and such plan were
22 a group health plan.

23 “(b) DEFINITIONS.—For purposes of this part:

24 “(1) ENROLLEE.—The term ‘enrollee’ means,
25 with respect to health insurance coverage offered by

1 a managed care plan, an individual enrolled with or
2 otherwise covered under the plan to receive such cov-
3 erage and includes a participant or beneficiary with
4 respect to a group health plan.

5 “(2) HEALTH PROFESSIONAL.—The term
6 ‘health professional’ means a physician or other
7 health care practitioner licensed, accredited, or cer-
8 tified to perform specified health services consistent
9 with law.

10 “(3) MANAGED CARE PLAN.—The term ‘man-
11 aged care plan’ means a group health plan or health
12 insurance coverage that provides or arranges for the
13 provision of health care items and services to partici-
14 pants, beneficiaries, or enrollees primarily through
15 participating physicians and providers.

16 “(4) NETWORK.—The term ‘network’ means,
17 with respect to a managed care plan, the partici-
18 pating health professionals and providers through
19 which the plan provides health care items and serv-
20 ices to enrollees.

21 “(5) NETWORK COVERAGE.—The term ‘network
22 coverage’ means coverage offered by a managed care
23 plan that provides or arranges for the provision of
24 health care items and services to enrollees through
25 participating health professionals and providers.

1 “(6) PARTICIPATING.—The term ‘participating’
2 means, with respect to a health professional or pro-
3 vider, a health professional or provider that provides
4 health care items and services to enrollees under
5 network coverage under an agreement with the man-
6 aged care plan offering the coverage.

7 “(7) PRIOR AUTHORIZATION.—The term ‘prior
8 authorization’ means the process of obtaining prior
9 approval from a managed care plan as to the neces-
10 sity or appropriateness of receiving medical or clin-
11 ical services for treatment of a medical or clinical
12 condition.

13 “(8) PROVIDER.—The term ‘provider’ means a
14 health organization, health facility, or health agency
15 that is licensed, accredited, or certified to provide
16 health care items and services.

17 “(9) SERVICE AREA.—The term ‘service area’
18 means, with respect to a managed care plan, the ge-
19 ographic area served by the plan with respect to the
20 coverage.

21 “(c) ENFORCEMENT.—For purposes of enforcing the
22 provisions of this part under this title, the provisions of
23 this part shall be treated as if they were part of subpart
24 2 of part A and as if they were part of subpart 2 of part
25 B (relating to other requirements).”.

1 (b) CONFORMING AMENDMENTS.—Title XXVII of
2 the Public Health Service Act is further amended—
3 (1) by redesignating the subpart 3 of part B re-
4 lating to other requirements as subpart 2; and
5 (2) in sections 2723(a)(1) (42 U.S.C. 300gg-
6 23(a)(1)) and subsections (a) and (b)(1) of section
7 2762 (42 U.S.C. 300gg-62), by striking “part C”
8 and inserting “part D” each place it appears.

9 **SEC. 3. PATIENT PROTECTION STANDARDS UNDER THE EM-**

10 **PLOYEE RETIREMENT INCOME SECURITY**
11 **ACT OF 1974.**

12 (a) IN GENERAL.—Subpart B of part 7 of subtitle
13 B of title I of the Employee Retirement Income Security
14 Act of 1974 is amended by adding at the end the following
15 new section:

16 **“SEC. 714. PATIENT PROTECTION STANDARDS.**

17 “(a) IN GENERAL.—Subject to subsection (b), a
18 group health plan (and a health insurance issuer offering
19 group health insurance coverage in connection with such
20 a plan) shall comply with the requirements of part C of
21 title XXVII of the Public Health Service Act.

22 “(b) REFERENCES IN APPLICATION.—In applying
23 subsection (a) under this part, any reference in such part
24 C—

1 “(1) to a managed care plan and health insurance
2 coverage offered by such a plan is deemed to
3 include a reference to a group health plan and coverage
4 under such plan, respectively; and

5 “(2) to the Secretary is deemed a reference to
6 the Secretary of Labor.

7 “(c) ENSURING COORDINATION.—The Secretary of
8 Health and Human Services and the Secretary of Labor
9 shall ensure, through the execution of an interagency
10 memorandum of understanding between such Secretaries,
11 that—

12 “(1) regulations, rulings, and interpretations
13 issued by such Secretaries relating to the same matter
14 over which such Secretaries have responsibility
15 under such part C and this section are administered
16 so as to have the same effect at all times; and

17 “(2) coordination of policies relating to enforcing
18 the same requirements through such Secretaries
19 in order to have a coordinated enforcement strategy
20 that avoids duplication of enforcement efforts and
21 assigns priorities in enforcement.”.

22 (b) MODIFICATION OF PREEMPTION STANDARDS.—
23 Section 731 of such Act (42 U.S.C. 1191) is amended—
24 (1) in subsection (a)(1), by striking “subsection
25 (b)” and inserting “subsections (b) and (c)”;

1 (2) by redesignating subsections (c) and (d) as
2 subsections (d) and (e), respectively; and

3 (3) by inserting after subsection (b) the fol-
4 lowing new subsection:

5 “(c) SPECIAL RULES IN CASE OF PATIENT PROTEC-
6 TION REQUIREMENTS.—Subject to subsection (a)(2), the
7 provisions of section 714 and part C of title XXVII of
8 the Public Health Service Act, and the provisions of this
9 subpart insofar as it applies to section 714 or such part,
10 shall not be construed to preempt any State law, or the
11 enactment or implementation of such a State law, that
12 provides protections for individuals that are equivalent to
13 or stricter than the protections provided under such provi-
14 sions.”.

15 (c) CONFORMING AMENDMENTS.—(1) Section 732(a)
16 of such Act (29 U.S.C. 1185(a)) is amended by striking
17 “section 711” and inserting “sections 711 and 714”.

18 (2) The table of contents in section 1 of such Act
19 is amended by inserting after the item relating to section
20 713 the following new item:

“Sec. 714. Patient protection standards.”.

21 (3) Section 734 of such Act (29 U.S.C. 1187) is
22 amended by inserting “and section 714(c)” after “of
23 1996”.

1 **SEC. 4. NONPREEMPTION OF STATE LAW RESPECTING LI-**2 **ABILITY OF MANAGED CARE PLANS.**

3 (a) IN GENERAL.—Section 514(b) of the Employee
4 Retirement Income Security Act of 1974 (29 U.S.C.
5 1144(b)) is amended by redesignating paragraph (9) as
6 paragraph (10) and inserting the following new para-
7 graph:

8 “(9) Subsection (a) of this section shall not be con-
9 strued to preclude any State cause of action to recover
10 damages for personal injury or wrongful death against any
11 person that provides insurance or administrative services
12 to or for a managed care plan. For purposes of this para-
13 graph, the term ‘managed care plan’ means a group health
14 plan (within the meaning of sections 732(d) and 733(a))
15 that provides or arranges for the provision of health care
16 items and services to participants or beneficiaries pri-
17 marily through participating physicians and providers.”.

18 (b) EFFECTIVE DATE.—The amendment made by
19 subsection (a) shall apply to causes of action arising on
20 or after the date of the enactment of this Act.

21 **SEC. 5. EFFECTIVE DATE.**

22 (a) IN GENERAL.—Subject to subsection (b), the
23 amendments made by sections 2 and 3 shall apply with
24 respect to group health plans for plan years beginning on
25 or after 90 days after the date of the enactment of this
26 Act, and also shall apply to portions of plan years occur-

1 ring on and after January 1, 2002. Such amendments
2 shall apply to individual health insurance coverage on and
3 after such date.

4 (b) SPECIAL RULE FOR PLANS UNDER COLLECTIVE
5 BARGAINING AGREEMENTS.—In the case of a group
6 health plan maintained pursuant to 1 or more collective
7 bargaining agreements between employee representatives
8 and 1 or more employers ratified before the date of enact-
9 ment of this Act, the amendments made by such sections
10 shall not apply to plan years beginning before the later
11 of—

12 (1) the date on which the last collective bar-
13 gaining agreements relating to the plan terminates
14 (determined without regard to any extension thereof
15 agreed to after the date of enactment of this Act);
16 or

17 (2) January 1, 2002.

18 For purposes of paragraph (1), any plan amendment made
19 pursuant to a collective bargaining agreement relating to
20 the plan which amends the plan solely to conform to any
21 requirement added by an amendment made by this Act
22 shall not be treated as a termination of such collective bar-
23 gaining agreement.

○